CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1035	**Date: AUGUST 18, 2006**
	Change Request 5214

SUBJECT: Updating Publication 100-04, Chapter 30 Regarding the CD ROM Initiative for the Annual "Dear Doctor" Mailing

I. SUMMARY OF CHANGES: Carriers conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with the opportunity to enroll in, or terminate enrollment from, the participation program. The purpose of this instruction is to update the Medicare Claims Processing Manual with information that was previously distributed in other change requests regarding the CD ROM initiative for the annual "Dear Doctor" mailing. This information provides guidance for carriers in their planning for the upcoming annual "Dear Doctor" CD ROM mailing. The manual had been been previously updated directing carriers to mail participation enrollment information on a CD-ROM.

NEW / REVISED MATERIAL
EFFECTIVE DATE: ***July 1, 2006**
IMPLEMENTATION DATE: September 18, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/30/30.3/Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims
R	1/30/30.3.12.1/Carrier Participation and Billing Limitations

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1035	Date: August 18, 2006	Change Request 5214

SUBJECT: Updating Publication 100-04, Chapter 30 Regarding the CD ROM Initiative for the Annual "Dear Doctor" Mailing

I. GENERAL INFORMATION

A. Background: Carriers conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision by December 31. The open enrollment period runs from November 15 to December 31 of each year. Carriers mail the participation material including the new Medicare Physician Fee Schedule fees on a CD ROM. Last November, Change Request 4051, Transmittal 730, issued on October 28, 2005, instructed carriers, among other things, not to place the new fees on the CD ROM. The purpose of this CR is to update the manual with information that was previously distributed in prior CRs regarding the CD ROM initiative for the "Dear Doctor" mailing. This information provides guidance to carriers in their planning for the upcoming annual "Dear Doctor" mailing in November. Carriers will also continue to post the new fees on their Web sites once the Medicare Physician Fee Schedule Regulation is put on display.

B. Policy In order to facilitate the annual participation enrollment, carriers undertake a mass mailing of "Dear Doctor" material on a CD ROM to all physicians in their jurisdiction in early November. The Medicare Claims Processing Manual (Pub. 100-04, Chapter 1, Section 30) is being updated to state that the fee schedule will be placed on the carriers' web site and not on the CD-ROM. This is not a new change, however, the manual needs to be revised to include this information that was introduced in a one time only change request last November (CR 4051). Additional information is also being added to the manual that provides guidance to carriers in their planning stages for producing a CD ROM for the upcoming "Dear Doctor" mailing. The additional information/guidance is not new but has been provided in prior CRs.

In addition, carriers shall no longer submit the completed evaluation reports as described in CR 3891, Transmittal 157, dated June 3, 2005. As usual, the CMS will be issuing a separate change request in October which will instruct carriers on the November 2006 mailing of the CD ROM.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5214.1	Contractors shall be in compliance with the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, Sections 30.3 and 30.3.12.1.			X						
5214.2	Contractors shall not place the new MPFS fees on the future CD ROMs.			X						
5214.3	Contractors shall place the new fees on their Web site after the final rule is put on display as stated in Section 30.3.12.1 B.			X						
5214.3.1	Contractors shall include a statement on the CD-ROM advising providers that the new fees are not available on the CD-ROM, but are posted on the carrier web site.			X						
5214.3.2	By October 2, 2006, contractors shall post a notice on their Web sites reminding providers that the upcoming Medicare Physician Fee Schedule will not be included on the CD-ROM but will be posted on the carrier Web site after the final rule is put on display.			X						
5214.4	Contractors shall provide a final CD ROM disk to the central office contact. See Section 30.3.12.1 B for the mailing address.			X						
5214.5	Contractors shall no longer submit an evaluation report to CMS as requested in change request 3891,transmittal 157, dated June 3, 2005.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2006 (not date of service) **Implementation Date:** September 18, 2006 except where noted in BR 5214.3.2. **Pre-Implementation Contact(s):** April Billingsley at 410-786-0140 or April.Billingsley@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

30.3 - Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims

(Rev. 1035, Issued: 08-18-06, Effective: 07-01-06, Implementation: 09-18-06)

Institutional providers (those that bill Fiscal Intermediaries (FIs)) are paid direct by the FI. In contrast, physicians, practitioners, and suppliers that bill the carrier may choose to enter into a participation agreement.

Carrier "Participating Providers" are paid at 100 percent of the physician fee schedule and must accept assignment (must accept program payment as payment in full, except for any unmet deductible and coinsurance). "Non-participating providers" are paid at 95 percent of the physician fee schedule and may accept assignment on a claim-by-claim basis.

Physicians and suppliers enrolled in the Medicare program under the Form CMS-855 process do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment. However, there is a 5 percent reduction in the Medicare approved amounts if the physician or his/her reassignee does not participate. Participation is an election that is optional to suppliers, even those that have to bill assigned.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. This is covered in the instructions in later chapters for each service type.

30.3.12.1 - Carrier Participation and Billing Limitations

(Rev. 1035, Issued: 08-18-06, Effective: 07-01-06, Implementation: 09-18-06)

A Participation Period

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin on November 15 of each year. Carriers will receive the participation enrollment material under separate cover.

NOTE: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the Final Rule.

B Participation Enrollment and Fee Disclosure Process

The CMS will furnish carriers, via a separate instruction, with the participation materials used for the annual participation open enrollment period. *Carriers mail* the annual participation materials *on a CD-ROM. Carriers must place the new fees and the anesthesia conversion factor(s) on their web site after the final rule is placed on display. Carriers shall not include the new fees on the CD-ROM. CMS has decided not to place the fees on the CD-ROM in order to have greater flexibility for making any last minute changes to the payment rate. Placing the fees on the carriers web sites assures that providers will have the most current and correct fees available.* The CMS transmits the MPFSDB electronically to carriers each year around mid-October.

Carriers must include additional supplemental materials in the CD-ROM to enhance its use and value to providers; and, are free to decide which supplemental materials to include. However, CMS may instruct all carriers to include a specific item(s) as part of the additional supplemental material on the CD-ROM (example: a note from the administrator, a special file, etc.). *Carriers need to include an insert, or indicate on the envelope, instructions for providers on how to access the data on the CD. Carriers also need to include information regarding whom the provider can contact if assistance is required.*

Each October, carriers should post a notice on their web site regarding the upcoming participation enrollment period reminding physicians and practitioners that the upcoming MPFS will be published on the carriers web site after the physician fee schedule regulation is put on display.

The carrier mails the participation enrollment CD-ROM and/or hardcopy fee disclosure packages via first class or equivalent delivery service, and schedules the release of material so that providers receive it no later than date provided in a temporary instruction each year.

As part of the final mailing, carriers should send a final CD ROM to central office. The mailing address is:

Director of the Division of Practitioner Claims Processing

Centers for Medicare & Medicaid Services

7500 Security Blvd.

Baltimore, MD 21244

The CD-ROMs are sent to the following physicians and suppliers in accordance with the following guidelines no later than November 15 of each year, subject to the publication of the Final Rule:

- All physician specialties included in the 01-99 specialty range;
- Independently practicing occupational and physical therapists (specialty 65 and 67);
- Suppliers of diagnostic tests;
- Suppliers of radiology services (including portable x-ray suppliers-specialty 63);
- Multi-specialty clinics (specialty 70);
- Independent laboratories (specialty 69-since they can typically bill for anatomic pathology services paid under the Physician Fee Schedule);
- Mammography Screening Centers (specialty 45);
- Independent Diagnostic Testing Facilities (specialty 47);
- Audiologists (specialty 64); and

- Independently Billing Psychologists (specialty 62).

NOTE: Chiropractors and Mammography Screening Centers do not need to view the entire locality fee schedule report. Therefore, carriers may add separate headings on *their web site* listing the fee data for the procedure codes that they may receive payment.

Carriers send an annual participation announcement and a blank participation agreement to the following non-participating suppliers:

- Ambulatory Surgical Centers (ASCs) (specialty 49); (Although ASCs must accept assignment for ASC facility services, they may also provide and bill for non-ASC facility services, which do not have to be billed as assigned and which are therefore subject to a participation election); and,

- Supplier specialties other than 51-58; (Supplier specialties 51-58 will receive a separate enrollment package from the National Supplier Clearinghouse).

Carriers may create *hard copy* fee disclosure reports and send them to specialty 49, and supplier specialties other than 51-58, if cost effective to do so (e.g., carriers determine that fee disclosure to suppliers will reduce the number of more costly supplier inquiries for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for supplier fee disclosure, carriers include a disclaimer advising the supplier that the non-participating fee schedule amounts and limiting charges do not apply to services or supplies unless they are paid for under the Physician Fee Schedule. If carriers elect not to routinely disclose supplier fees with their participation enrollment packages, they must furnish suppliers with their applicable fee schedules or reasonable charge screens upon request.

Instructions for completing the enrollment process for non-durable medical equipment, prosthetic, orthotic, and supplies (DMEPOS) suppliers will be issued under separate cover. Those instructions will address the responsibilities of local carriers, durable medical equipment regional carriers (DMERCs), and the National Supplier Clearinghouse.

C Minimum Requirements for Disclosure Reports *for Posting on the Web and Hard Copies*

Carriers must place the following information on the web sites and also in their hard copy disclosure reports.

- Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule *services when posting this information on the web. Carriers* provide complete locality data for all procedure codes with a status indicator of A, T, and R (for which CMS has established the RUVs) on the Medicare Physician Fee Schedule Database. *L*imiting charges *are included* on the annual disclosure reports of providers who may be subject to the nonparticipant fee schedule amount, if they elect not to participate for a calendar year. The limiting charge equals 115 percent of the nonparticipant fee schedule amount.

For the facility setting differential, the limiting charge is 115 percent of the nonparticipant fee for the differential amount.

The data for Locality Fee Schedule Reports are:

--Header Information – Locality identification (on each report page);

--Procedure Codes – Carriers must array all codes paid under the Physician Fee Schedule. They include global, professional component and technical component entries where applicable:

--Par Amount (nonfacility);

--Par Amount (facility based);

--Non-par Amount (nonfacility);

--Limiting Charge (nonfacility):

--Non-par Amount (facility based); and

--Limiting Charge (facility based);

--Footer Information – The following must be included on the fee disclosure reports:

1. The legend: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association" (on each report page).

NOTE: *The CMS has signed agreements with the American Medical Association regarding the use of CPT, and with the American Dental Association regarding the use of CDT, on Medicare contractor Web sites, bulletin boards and other contractor electronic communications. If the carrier uses descriptors, it must use short descriptors.*

2. The legend: "These amounts apply when service is performed in a facility setting."

For the disclosure reports, the carrier shall also provide the anesthesia conversion factors.

In addition, the carrier includes language in a bulletin that provides an explanation of the facility-based fee concept (e.g., facility-based fees are linked to their own separate RVUs independent of the non facility RVUs).

D Disclosure to Medical Societies and Other Parties

Carriers send first class or equivalent (e.g. UPS), free of charge, a complete fee schedule for the entire State (or your service area if it is other than the entire State) to State medical societies and State beneficiary associations. Carriers may negotiate with them as to the medium in which the information is to be furnished.

Carriers send local medical societies and beneficiary organizations a free copy of their respective locality fee schedule. If a fee schedule for the entire service area is requested by a local medical society or beneficiary organization, furnish one free copy. If more than one copy of a complete fee schedule for the carrier service area is requested, carriers charge for extra copies in accordance with the Freedom of Information Act (FOIA) rules. If a provider requests a fee

schedule for a locality in which he/she has no office, carriers may charge them in accordance with FOIA rules.

E Practitioners Subject to Mandatory Assignment

Some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance. The following practitioners must accept assignment for all Medicare covered services they furnish, and carriers do not send a participation enrollment package to these practitioners:

- Specialty 32 - Anesthesiologist assistants (AAs)
- Specialty 42 - Certified nurse midwives
- Specialty 43 - Certified registered nurse anesthetists (CRNAs)
- Specialty 50 - Nurse practitioners
- Specialty 68 - Clinical Psychologists
- Specialty 71 - Registered dietitians/nutritionists
- Specialty 73 - Mass Immunization Roster Billers
- Specialty 80 - Clinical Social Workers
- Specialty 89 - Clinical nurse specialists
- Specialty 97 - Physician assistants

NOTE: The provider type Mass Immunization Biller (specialty 73) can bill only for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

Although these practitioners will not be invited to officially enroll in the Medicare participation program, carriers treat them as participating practitioners for purposes of various benefits available under that program (See Section 30.3.12 in this Chapter).

NOTE: Although these practitioners do not have to sign participation agreements, carriers must include them in the annual MEDPARD as participating. They also include Rural Health Centers.

Carriers may create and send *hardcopy* fee disclosure reports to these practitioners if cost effective to do so (e.g., the carrier determines that fee disclosure to these practitioners will reduce or minimize the number of more costly inquiries it receives for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for practitioner fee disclosure, carriers include a disclaimer advising the practitioner that the non-participating fee schedule amounts and

limiting charges do not apply to services they furnish. If carriers elect not to routinely disclose practitioner fees, they furnish applicable fees or reasonable charge screens upon request.

The Medicare Participation Agreement and general instructions are on the CMS Web *site at http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf.*

F Supplier Fee Schedule Data

Refer to Chapter 23 for more information.

Clinical Laboratory Fee Schedule

Carriers must:

- Publish clinical diagnostic lab fees in a regularly scheduled bulletin or newsletter.
- Publish clinical laboratory fees in the following format:

o Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page;

o Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);

o Fee Schedule Amount; and

o Footer Information: The legend "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association." (on each report page).

Information regarding release of this data will be issued under separate cover.

DMEPOS Fee Schedule:

Instructions for furnishing DMEPOS fee schedule data will be issued annually by CMS.

G Fee Schedule Printing Specifications

Carriers are to produce *hardcopy disclosure material for no more than two percent of their total number of providers. Carriers have the discretion to produce either one or two percent hardcopy versions. The hard copy fee schedules are to be mailed to providers who are* ***unable*** *to access the carrier Web site (i.e, do not have internet access).* For those providers, carriers must print fee schedules on 8-1/2 by 11-inch paper, and use a print size that accommodates up to 15 characters per inch. The CMS prior approval for smaller print must be requested in writing from the RO. Requests are to be accompanied by print samples to assist the RO in assessing report readability.